STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00094797. Complaint IN00094797 - Substantiated. Federal/state deficiencies related to the allegations are cited at F281, F333, F514, and F9999. Survey dates: August 18 and 19, 2011 Facility number: 000057 Provider number: 155132 AIM number: 100266570 Survey team: Vanda Phelps, RN Census bed type: 11 SNF 76 SNF/NF 87 Total Census payor type: 15 Medicare 58 Medicaid 14 Other 87 Total Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. The facility is respectfully requesting a desk review .	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 8/24/11 by Jennie Bartelt, RN.			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interviews, the facility failed to ensure the nurse followed the five rights of medication administration while administering insulin to 1 of 3 residents in the sample of 3 reviewed for medication errors. (Resident F) Findings include: The closed clinical record of Resident F was reviewed on 8/18/11 at 1:12 p.m. The record indicated the resident was alert and oriented and had been admitted to recuperate from knee surgery. Her diagnoses included, but were not limited to, history of seizure disorder. This record did not include a diagnosis of diabetes, or physician orders for insulin or other diabetic medications or glucose monitoring. Nursing notes indicated entries on 7/30/11 at 12:30 p.m. and at 3:30 p.m., and on 7/31/11 at 1:00 a.m. for blood sugar monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of	F0281	Corrective actions: The nurse was educated/counseled as a result of the medication error by the DON. Resident vital signs were monitored and facility protocol was followed per medication error policy and procedure. The reident did not have a negative outcome .Other residents having the potential to be affected: No other residents were affected by the deficient practice. In the event a medication error isidentified facility policy and procedure will be followed.Systematic changes: An in-service will be completed regarding medication administratrion/rights of medication and pre-setting medication for all licensed nurses. Medication errors will be followed up by the DON and brought to daily clinical review (DCR) (5 days/week except for holidays and weekends) for IDT review upon each occurrence on an ongoing basis. MAR/TAR audits will be completed by the unit manager(s) or designee weekly x 4 weeks, then monthly x 2.Addendum per 9-7-11 ISDH request: If a resident photo cannot be placed on the MAR	09/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hyper or hypoglycemia." The Administrator and the Corporate Nurse Consultant were interviewed on 8/18/11 at 3:45 p.m. regarding these entries. The Administrator indicated Resident F had received an injection of insulin intended for another resident, but had not suffered any ill effects. Interview with Resident F on 8/18/11 at 6:26 p.m. indicated she had received an injection of insulin which was intended for the resident across the hall. She indicated she had not met the nurse who administered the medication before, having just been admitted the previous evening. She indicated the nurse came in with an injection, which she accepted because she was receiving injections of another medication twice daily. However, when the nurse returned right away with a second injection, she began questioning, because she knew she was not to get two injections at the same time. Despite her objections and questions, the nurse injected the medication and then told her it was Lovenox [for blood clot prevention], her usual medication. When she asked the nurse what was in the first injection, she was told it was insulin, and that was when they both realized the mistake.		upon admission, a resident ID bracelet will be placed on the resident until a picture can be placed on the MAR. Nurses will utilize the 5 rights of mdication pass to assist in ensuring medications are being provided to the correct resident(s). Medical Records or the Unit Manager will audit MAR's within 72 hours of admission to ensure pictures are in placeMonitoring: Medication errors will be monitored per faciity policy and procedure and taken through DCR and reviewed by IDT upon each occurrence on an ongoing basis. Medication errors will be brought to monthly QA on an ongoing basis.Date of completion: 9-16-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with LPN #1 was conducted on 8/18/11 at 7:16 p.m. She indicated she had injected Resident F with another resident's insulin, 20 units of Novalog 70/30, by mistake on Saturday July 31, 2011, between 7:00 and 8:00 a.m. In defense of herself , she indicated both residents had been admitted the previous evening and this was her first contact with either of them. She said she called Resident F by the other resident's name as she entered the room and Resident F had not corrected her. She indicated arm bands and photographs are not used on that unit, but the residents' names are posted by the doors. She indicated she had Resident F's oral medications with her, and the other resident's insulin instead of Resident F's Lovenox. Review of the Medication Error Report on 8/19/11 at 4:50 p.m. indicated a dose of 20 units of "Humalog 75/25 (sic)" was given to Resident F on 7/30/11 at 8:00 a.m. The report indicated the insulin was given to the wrong resident. Page 171 of the Geriatric Medication Handbook , eighth edition, indicated under "Steps of Medication Administration" that the five administration rights included: "accurate medication administration (i.e., right drug, right patient, right dose, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dosage form, right time)" The personnel file of LPN #1 was reviewed on 8/19/11 at 2:30 p.m. The file indicated LPN #1's employment was terminated on 8/1/11 for "serious medication error that could have resulted in harm to resident," and failure to follow the five rights of medication administration. This federal tag relates to Complaint IN00094797. 3.1-35(g)(1)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews, the facility failed to ensure 1 of 3 residents sampled for medication errors in the total sample of 3 was free of significant medication error, in that she received insulin which was not ordered for her. (Resident F) Findings include: The closed clinical record of Resident F	F0333	Corrective actions: The nurse was educated/counseled as a result of the medication error by the DON. Resident vital signs were monitored and facility protocol was followed per medication error policy and procedure. The Resdient did not have a negative outcome Other residents having the potential to be affected: No other residents were affected by the deficient practice. In the event a medication error is identified ,	09/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was reviewed on 8/18/11 at 1:12 p.m. The record indicated the resident was alert and oriented and had been admitted to recuperate from knee surgery. Her diagnoses included, but were not limited to, history of seizure disorder. The record did not indicate a diagnosis of diabetes, or physician orders for insulin or other diabetic medications or glucose monitoring. The nursing notes indicated entries on 7/30/11 at 12:30 p.m. and at 3:30 p.m., and on 7/31/11 at 1:00 a.m. documenting blood sugar monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of hyper [high] or hypoglycemia [low blood sugar]." The Administrator and the Corporate Nurse Consultant were interviewed on 8/18/11 at 3:45 p.m. regarding these entries. The Administrator indicated Resident F had received an injection of insulin intended for another resident, but had not suffered any ill effects. Interview with Resident F on 8/18/11 at 6:26 p.m. indicated she had received an injection of insulin which was intended for the resident across the hall. She indicated she had not met the nurse who administered the injection before, having just been admitted the previous evening.		facility policy and procedure will be followed.Systematic changes: An in-service will be completed regarding medication administratrion/rights of medication pass and pre-setting injections for all licensed nurses. Medication errors will be followed up by the DON and brought to daily clinical review (DCR) for IDT review upon each occurrence.Monitoring: Medication errors will be monitored per faciity policy and procedure and taken through DCR and reviewed by IDT upon each occurrence on an ongoing basis. Medication errors will be brought to monthly QA on an ongoing basis.Date of completion: 9-16-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated the nurse came in with an injection, which she accepted because she was receiving injections of another medication twice daily. However, when the nurse returned right away with a second injection, she began questioning, because she knew she was not to get two injections at the same time. Despite her objections and questions, the nurse injected the medication and then told her it was Lovenox [for blood clot prevention], her usual medication. When she asked the nurse what was in the first injection, she was told it was insulin and that was when they both realized the mistake. She indicated she had been very afraid the insulin would cause her to have a seizure. She said she became very anxious and was "crying uncontrollably." Interview with the attending physician on 8/18/11 at 4:24 p.m. indicated he remembered a nurse calling him to report the error. He recalled giving her a verbal order to monitor the blood sugars and the resident's overall condition every two hours for six to eight hours. He added he tried to calm the nurse's fears by explaining when a nondiabetic receives insulin, it is usually not a problem because the person's own body would just not produce its own insulin, until the effects of the injection had worn off, but, nonetheless, it warranted close			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monitoring. The physician's verbal order was not recorded in the nursing notes or the physician order section, nor was the fact he was notified recorded in the record. Interview with LPN #1 was conducted on 8/18/11 at 7:16 p.m. She indicated she had injected Resident F with another resident's insulin, 20 units of Novalog 70/30, by mistake on Saturday July 31, 2011, between 7:00 and 8:00 a.m. She indicated the Director of Nursing had instructed her to monitor the resident's blood sugar every one hour all day, which she did. In defense of herself, she indicated both residents had been admitted the previous evening and this was her first contact with either of them. She said she called Resident F by the other resident's name as she entered the room, and Resident F had not corrected her. Review of the Medication Error Report on 8/19/11 at 4:50 p.m. indicated a dose of 20 units of "Humalog 75/25 (sic)" was given to Resident F on 7/30/11 at 8:00 a.m. The report indicated the medication was given to the wrong resident. On this form, a physician's order was documented as check blood sugar at 11:00 a.m., give orange juice and snacks accordingly. There were no physician orders within the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinical record of Resident F regarding this or anything about checking blood sugars at all. This federal tag relates to Complaint IN00094797. 3.1-25(b)(9) 3.1-48(c)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interviews, the facility failed to ensure the medical record was complete. Critical charting regarding a medication error of giving insulin to the wrong resident and subsequent actions was purposefully	F0514	Corrective actions: no negative outcome occurred with identified resident. Medication error was reported to the physician and DON. Orders received to monitor resident. Medication error report was completed per policy and	09/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	omitted from the medical record per corporate policy. This impacted 1 of 3 residents reviewed related to medication errors in a sample of 3. (Resident F) Findings include: The closed clinical record of Resident F was reviewed on 8/18/11 at 1:12 p.m. The record indicated this resident was alert and oriented and had been admitted to recuperate from knee surgery. Her diagnoses included, but were not limited to, history of seizure disorder. The record did not indicate a diagnosis of diabetes, or physician orders for insulin or other diabetic medications or glucose monitoring. The nursing notes indicated entries on 7/30/11 at 12:30 p.m. and at 3:30 p.m., and on 7/31/11 at 1:00 a.m. documenting blood sugar monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of hyper [high] or hypoglycemia [low blood sugar]." The social service progress notes indicated the Administrator had spoken with Resident F on 8/1/11 regarding her complaints "related to the med error that occurred." The Administrator and the Corporate Nurse Consultant were interviewed on 8/18/11 at 3:45 p.m. The Administrator		procedureOther residents having potential to be affected: in order to identify other residents at risk an audit will be completed to compare physician orders and MAR's to ensure that they match. No other residents were identified as being at riskSystematic changes: In-service education will be completed for licensed nurses on the rights of medication and not pre-setting medications. Weekly random audits x 4 weeks, then monthly random audits x 2 months will be completed by DON/Unit Manager's to review medication pass and lovenox/insulin injections to ensure following policy and procedureMonitoring: Findings of the random audits will be brought to monthly QA for 6 months to ensure compliance.Date of completion: 9-16-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident F had been unhappy, because staff did not go out to get her Taco Bell food when she asked for it. When asked specifically about the medication error referenced in the entry, the Administrator indicated Resident F had received an injection of insulin intended for another resident, but had not suffered any ill effects. She and the Corporate Nurse Consultant both indicated it was corporate policy to record all the specifics of any medication error on a corporate form titled, "Medication Error Report" and give the report to the Director of Nursing for further action. The specifics of the medication error were not then repeated in the resident's medical record. The Medication Error Report would eventually be connected to the nurse's personnel file, but would not become part of the resident's record. Interview with the Director of Nursing on 8/18/11 at 4 p.m. indicated when LPN #1 called to report the error to her, she instructed the nurse to file a Medication Error Report and put it under her door. The Director of Nursing indicated all the details are to be put onto the form and not in the nursing notes. She indicated this was not a problem "because the resident had no ill effects." She also indicated this was corporate policy. Interview with Resident F on 8/18/11 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6:26 p.m. indicated she had received an injection of insulin which was intended for the resident across the hall. She indicated she had not met the nurse who administered the medication before, having just been admitted the previous evening. She indicated the nurse came in with an injection, which she accepted because she was receiving injections of another medication twice daily. However, when the nurse returned right away with a second injection, she began questioning because she knew she was not to get two injections at the same time. Despite her objections and questions, the nurse injected the medication and then told her it was Lovenox [for blood clot prevention], her usual medication. When she asked the nurse what was in the first injection, she was told it was insulin and that was when they both realized the mistake. She indicated she had been afraid the insulin would cause her to have a seizure. She said she became very anxious and was "crying uncontrollably." Interview with the attending physician on 8/18/11 at 4:24 p.m. indicated he remembered a nurse calling him to report the error. He recalled giving her a verbal order to monitor the blood sugars and the resident's overall condition every two hours for six to eight hours. He added he tried to calm the nurse's fears by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	explaining when a nondiabetic receives insulin, it is usually not a problem because the person's own body would just not produce its own insulin until the effects of the injection had worn off, but nonetheless, it warranted close monitoring. The physician's verbal order was not recorded in the nursing notes or the physician order section, nor was the fact he was notified recorded in the record. Interview with LPN #1 was conducted on 8/18/11 at 7:16 p.m. She indicated she had injected Resident F with her neighbor's insulin, 20 units of Novalog 70/30, by mistake, on Saturday July 31, 2011, between 7:00 and 8:00 a.m. She indicated she immediately called the physician who had calmed her fears somewhat when he explained a negative effect on a nondiabetic would probably not occur. However, she'd still been very upset and also called her Director of Nursing. She was instructed to file a Medication Error Report form and put it under the Director's door, which she did. She indicated the Director of Nursing had instructed her to monitor the resident's blood sugar every one hour all day, which she did. She indicated she'd documented exactly as directed. Review of the Medication Error Report on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8/19/11 at 4:50 p.m., indicated a dose of 20 units of Humalog 75/25 (sic) was given to Resident F on 7/30/11 at 8:00 a.m. The report indicated the medication was given to the wrong resident. On this form a physician's order was documented for checking blood sugar at 11:00 a.m. and giving orange juice and snacks accordingly. This order had not been recorded in the medical record. Review of the Medication Error policy and procedure presented for review on 8/18/11 at 4:06 p.m. by the Corporate Nurse Consultant, indicated it instructed staff in the following: "page 2: Procedure: 5. Identify resident before medication is administered.... 7. Administer medications only to the residents for whom they are ordered.... 11. Complete the *Medication Error Report* on all residents who are involved in a medication error..... 16. Place the *Medication Error Report* in a designated administrative file. Note: *Do not place the Medication Error Report in the medical record*." This federal tag relates to Complaint IN00094797. 3.1-25(b)(9) 3.1-50(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	3.1-50(a)(2) STATE FINDINGS 3.1-13 ADMINISTRATION The administrator is responsible for the overall management of the facility, but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. This rule was not met as evidenced by: Based on record review and interviews, the facility failed to notify the State Department of Health of an unusual	F9999	Corrective action: an incident report on state form 6-04 has been sent to ISDH regarding the identified event. No negative outcome occurred for identified resident.Other residents having the potential to be affected: No other residents were affected by the alleged deficient practice. Medication error(s) will be reviewed by Admn, DON and Regional Direction of Clinical Services (RDCS) to see if special monitoring is required that will result in reporting to ISDH.Systematic changes: All medication errors will be reported to RDCS and by the DON or designee and reviewed for potential reporting to ISDH. Other incidents in accordance with state reporting guidelines will be brought to the attention of the Regional Director of Operations (RDO) by the Administrator upon each occurrence for review and oversight. Unusual occurrences will be reported immediately to the Administrator. All accidents and incidents will be reviewed 5	09/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occurrence having the potential of great harm to the resident. This was related to giving insulin to the wrong resident and impacted 1 of 3 residents sampled for medication errors in a total sample of 3 residents. (Resident F) Findings include: The closed clinical record of Resident F was reviewed on 8/18/11 at 1:12 p.m. The record indicated this resident was alert and oriented and had been admitted to recuperate from knee surgery. Her diagnoses did not include diabetes. Although there was not a diagnosis of diabetes, neither physician orders for insulin or other diabetic medications nor glucose monitoring. The nursing note review indicated entries on 7/30/11 at 12:30 p.m. and at 3:30 p.m.and on 7/31/11 at 1 a.m. documented blood sugar monitoring and notations the resident was "asymptomatic" and/or "there were no signs or symptoms of hyper or hypoglycemia." The Administrator and the Corporate Nurse Consultant were interviewed on 8/18/11 at 3:45 p.m. The Administrator indicated Resident F had received an injection of insulin intended for another resident, but had not suffered any ill		days/week (excluding holidays and weekends) by IDT, DON & Admn. Monitring: ISDH reportables will be brought through DCR daily/5 days/week (excluding holidays and weekends) to ensure investigation and final disposition has been completed per regulation. DON and Administrator will monitor internal process upon each occurrence and bring forward to monthly QA for review on an ongoing basis.Date of completion: 9-16-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	effects. Interview with Resident F on 8/18/11 at 6 :26 p.m. indicated she had received an injection of insulin which was intended for the resident across the hall. She indicated she had not met this nurse before, having just been admitted the previous evening. She indicated the nurse came in with an injection, which she accepted because she was receiving injections of another medication twice daily. However, when the nurse returned right away with a second injection, she began questioning because she knew she was not to get two injections at the same time. Despite her objections and questions, the nurse injected the medication and then told her it was Lovenox, her usual medication. When she asked the nurse what was in the first injection, she was told it was insulin and that was when they both realized the mistake. Interview with LPN #1 was conducted on 8/18/11 at 7:16 p.m. She indicated she had injected Resident F with her neighbor's insulin, 20 units of Novalog 70/30, by mistake on Saturday July 31, 2011 between 7 and 8 a.m. She indicated she immediately called the physician and also called her Director of Nursing. She was instructed to file a Medication Error			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Report form and put it under the Director's door, which she did. She indicated her employment was terminated two days later due to this error. The Administrator indicated the error had not been reported to the Indiana State Department of Health, because "it doesn't fit the criteria." This state finding relates to Complaint IN00094797. 3.1-13(g)(1)			